South Carolina Department of Disabilities and Special Needs

REPORT ON MANAGEMENT REVIEW OF ALLEGED ABUSE, NEGLECT, OR EXPLOITATION

Please provide brief summarized information in this report—explicit details should be provided according to the Outline of Report)

The Management Review is done when the state investigative agency conducts a review of the alleged abuse, neglect, or exploitation. The alleged ANE occurred while a consumer resided in a non-ICF home operated or contracted for operation by DDSN or while consumer was under the jurisdiction of an agency or contracted employee, to include respite services, rehabilitation supports, companion services, etc.

Reviewer:	Name:	Position:	Date/Time Appointed:	
Provider:				

Victim 1:	Date of Birth:	Victim 3:	Date of Birth:
Victim 2:	Date of Birth:	Victim 4:	Date of Birth:

Alleged Perpetrator(s)	Name & Title (indicate which victim #):

Residence of Consumer:	☐ Family/guardian home or own home ☐ CRCF ☐ CTH I ☐ CTH II ☐ SLP I ☐ SLP II ☐ Other (i.e., boarding home)	Descriptive Location of Residence: (i.e., family home, own home, Jim Doe CTH I)

INCIDENT:

Date of Incident:	
If Date of Incident is unknown, indicate Date Incident reported (also shown on Initial Report):	
Type Location of Incident:	☐ Family/guardian home or own home ☐CRCF ☐ CTH I ☐ CTH II ☐SLP I ☐SLP II ☐Day Service Descriptive Location of Incident (i.e., family home, own home, Jim Doe CTH I):

Facts pertaining to the incident:

MANAGEMENT ISSUES/RISK SITUATIONS IDENTIFIED:

☐ Personnel Actions	Comment:
☐ Staff Training	Comment:
☐ Environmental Modifications	Comment:
☐ Policy/Procedure Violations	Comment:
☐ Local Services Contract	Comment:
☐ Awareness Training for People Served	Comment:

Recommendations Pertaining to These Issues/Situations:

REVIEW OUTCOME:

☐ Rules, Regulation or Policy Violation(s)
(Specify which rule, regulation or policy was violated):

☐ Management Action Taken (Specify what action was taken):	☐ Other (Specify):

Comments:

ACTION TAKEN/TO BE TAKEN:

Personnel Action Taken:
☐ Administrative Leave W/Out Pay ☐ In-Service Training ☐ Legal Charges ☐ NA/No Staff Involved
☐ None ☐ Reinstatement ☐ Resignation/No Longer Works for Agency
☐ Transferred ☐ Unknown ☐ Verbal Reprimand ☐ Written Reprimand

Comments:

Abuse Prevention/Corrective Action to Avoid Reoccurrence: *(Include each action, completion date, staff responsible for implementation of each action and staff title)*

Other Action Taken:

OUTSIDE INVESTIGATIVE AGENCIES:

Has an investigation by an outside agency been completed ☐ Yes ☐ No
Or, is the case still under investigation by an outside agency? ☐ Yes ☐ No

Agency	*Date of Referral*	*Contact Person*	*Intake # or Case ID #*	*Result of Agency's Investigation If Known at Time of Completion of Management Review*
☐ DSS				
☐ Local Law Enforcement				
☐ Ombudsman				
☐ SLED				
☐ Attorney General				
☐ Other (Specify):				

FINDINGS BASED ON MANAGEMENT REVIEW:

(please provide only brief summary information pertaining to the conclusion of the review)

Disposition of Abuse Allegation: (at time of review) ☐ Substantiated/Founded (Perpetrator Known) ☐ Substantiated/Founded (Perpetrator Unknown) ☐ Unsubstantiated/Unfounded ☐ Other Agency Investigating

OUTLINE OF REPORT *(Attach detailed information according to this outline which pertains to the alleged abuse):*

A. *Chronology of Events*

This section shall include in paragraph form, the re-creation of the events prior to, during, and following the incident of alleged abuse. It shall contain, to the extent possible, the names of the individuals, their action, and the time frame during which the alleged abuse occurred.

B. *Discussion*

This section will list all facts of the case.

C. *Conclusion*

D. *Supporting Documents to be Included*

1. Unusual Occurrence Form
2. Photographs
3. OD Report
4. Injury Report
5. Other documents, if needed during the Management Review, such as:
   a. Body check report
   b. Doctor/Nurse reports
   c. Work schedule
   d. Security report

SIGNATURE:

Executive Director/ CEO/ Facility Administrator (or Designee)	Date	Name of Person Completing Form

Send completed form within ten (10) working days (excluding state and federal holidays) in which the suspected abuse, neglect, or exploitation is discovered to: Director of Quality Management, SCDDSN, PO Box 4706, Columbia, SC 29240, FAX # 803.898.7450

Form for Policy 534-02-DD; Form Effective 1/12/09